

National Population Policy 2000 - INTRODUCTION

- 1 The overriding objective of economic and social development is to improve the quality of lives that people lead, to enhance their well-being, and to provide them with opportunities and choices to become productive assets in society.
- 2 In 1952, India was the first country in the world to launch a national programme, emphasizing family planning to the extent necessary for reducing birth rates "to stabilize the population at a level consistent with the requirement of national economy"¹. After 1952, sharp declines in death rates were, however, not accompanied by a similar drop in birth rates. The National Health Policy, 1983 stated that replacement levels of total fertility rate² (TFR) should be achieved by the year 2000.
- 3 On 11 May, 2000 India is projected to have 1 billion³ (100 crore) people, i.e. 16 percent of the world's population on 2.4 percent of the globe's land area. If current trends continue, India may overtake China in 2045, to become the most populous country in the world. While global population has increased threefold during this century, from 2 billion to 6 billion, the population of India has increased nearly five times from 238 million (23 crores) to 1 billion in the same period. India's current annual increase in population of 15.5 million is large enough to neutralize efforts to conserve the resource endowment and environment.

Box 1: India's Demographic Achievement

Half a century after formulating the national family welfare programme, India has:

- ? reduced crude birth rate (CBR) from 40.8 (1951) to 26.4 (1998, SRS);
- ? halved the infant mortality rate (IMR) from 146 per 1000 live births (1951) to 72 per 1000 live births (1998, SRS);
- ? quadrupled the couple protection rate (CPR) from 10.4 percent (1971) to 44 percent (1999);
- ? reduced crude death rate (CDR) from 25 (1951) to 9.0 (1998, SRS);
- ? added 25 years to life expectancy from 37 years to 62 years;
- ? achieved nearly universal awareness of the need for and methods of family planning, and
- ? reduced total fertility rate from 6.0 (1951) to 3.3 (1997, SRS).

- 4 India's population in 1991 and projections to 2016 are as follows:

Table 1: Population Projections for India (million)³

March 1991	March 2001	March 2011	March 2016
846.3	1012.4	1178.9	1263.5

¹ Milestones in the Evolution of the Population Policy are listed at Appendix II, page 30

2 TFR: Average number of children born to a woman during her lifetime.
3 Source: Technical Group on Population Projections, Planning Commission.

5 Stabilising population is an essential requirement for promoting sustainable development with more equitable distribution. However, it is as much a function of making reproductive health care accessible and affordable for all, as of increasing the provision and outreach of primary and secondary education, extending basic amenities including sanitation, safe drinking water and housing, besides empowering women and enhancing their employment opportunities, and providing transport and communications.

6 The National Population Policy, 2000 (NPP 2000) affirms the commitment of government towards voluntary and informed choice and consent of citizens while availing of reproductive health care services, and continuation of the target free approach in administering family planning services. The NPP 2000 provides a policy framework for advancing goals and prioritizing strategies during the next decade, to meet the reproductive and child health needs of the people of India, and to achieve net replacement levels (TFR) by 2010. It is based upon the need to simultaneously address issues of child survival, maternal health, and contraception, while increasing outreach and coverage of a comprehensive package of reproductive and child health services by government, industry and the voluntary non-government sector, working in partnership.

OBJECTIVES

1 The immediate objective of the NPP 2000 is to address the unmet needs for contraception, health care infrastructure, and health personnel, and to provide integrated service delivery for basic reproductive and child health care. The medium-term objective is to bring the TFR to replacement levels by 2010, through vigorous implementation of inter-sectoral operational strategies. The long-term objective is to achieve a stable population by 2045, at a level consistent with the requirements of sustainable economic growth, social development, and environmental protection.

2 In pursuance of these objectives, the following National Socio-Demographic Goals to be achieved in each case by 2010 are formulated:

Box 2: National Socio-Demographic Goals for 2010

- ? Address the unmet needs for basic reproductive and child health services, supplies and infrastructure.
- ? Make school education up to age 14 free and compulsory, and reduce drop outs at primary and secondary school levels to below 20 percent for both boys and girls.
- ? Reduce infant mortality rate to below 30 per 1000 live births.
- ? Reduce maternal mortality ratio to below 100 per 100,000 live births.
- ? Achieve universal immunization of children against all vaccine

preventable diseases.

- ? Promote delayed marriage for girls, not earlier than age 18 and preferably after 20 years of age.
- ? Achieve 80 percent institutional deliveries and 100 percent deliveries by trained persons.
- ? Achieve universal access to information/counseling, and services for fertility regulation and contraception with a wide basket of choices.
- ? Achieve 100 per cent registration of births, deaths, marriage and pregnancy.
- ? Contain the spread of Acquired Immunodeficiency Syndrome (AIDS), and promote greater integration between the management of reproductive tract infections (RTI) and sexually transmitted infections (STI) and the National AIDS Control Organisation.
- ? Prevent and control communicable diseases.
- ? Integrate Indian Systems of Medicine (ISM) in the provision of reproductive and child health services, and in reaching out to households.
- ? Promote vigorously the small family norm to achieve replacement levels of TFR.
- ? Bring about convergence in implementation of related social sector programs so that family welfare becomes a people centred programme.

If the NPP 2000 is fully implemented, we anticipate a population of 1107 million (110 crores) in 2010, instead of 1162 million (116 crores) projected by the Technical Group on Population Projections:

Table 2: Anticipated Growth in Population (million)

Year	If current trends continue		If TFR 2.1 is achieved by 2010
	Total Population	Increase in population	Total population
1991	846.3	-	846.3
1996	934.2	17.6	934.2
1997	949.9	15.7	949.0
2000	996.9	15.7	991.0
2002	1027.6	15.4	1013.0
2010	1162.3	16.8	1107.0

Similarly, the anticipated reductions in the birth, infant mortality and total fertility rates are:

Table 3: Projections of Crude Birth Rate, Infant Mortality Rate, and TFR, if the NPP 2000 is fully implemented.

Year	Crude Birth Rate	Infant Mortality Rate	Total Fertility Rate
1997	27.2	71	3.3
1998	26.4	72	3.3
2002	23.0	50	2.6
2010	21.0	30	2.1

Source for Tables 2 and 3: Ministry of Health and Family Welfare

3 Population growth in India continues to be high on account of :

- ? The large size of the population in the reproductive age-group (estimated contribution 58 percent). An addition of 417.2 million between 1991 and 2016 is anticipated despite substantial reductions in family size in several states, including those which have already achieved replacement levels of TFR. This momentum of increase in population will continue for some more years because high TFRs in the past have resulted in a large proportion of the population being currently in their reproductive years. It is imperative that the the reproductive age group adopts without further delay or exception the "small family norm", for the reason that about 45 percent of population increase is contributed by births above two children per family.
- ? Higher fertility due to unmet need for contraception (estimated contribution 20 percent). India has 168 million eligible couples, of which just 44 percent are currently effectively protected. Urgent steps are currently required to make contraception more widely available, accessible, and affordable. Around 74 percent of the population lives in rural areas, in about 5.5 lakh villages, many with poor communications and transport. Reproductive health and basic health infrastructure and services often do not reach the villages, and, accordingly, vast numbers of people cannot avail of these services.
- ? High wanted fertility due to the high infant mortality rate (IMR) (estimated contribution about 20 percent). Repeated child births are seen as an insurance against multiple infant (and child) deaths and accordingly, high infant mortality stymies all efforts at reducing TFR.
- ? Over 50 percent of girls marry below the age of 18, the minimum legal age of marriage, resulting in a typical reproductive pattern of "too early, too frequent, too many". Around 33 percent births occur at intervals of less than 24 months, which also results in high IMR.

The country's demographic profile is given in Appendix III (pages 32-35).

STRATEGIC THEMES

1 We identify 12 strategic themes which must be simultaneously pursued in "stand alone" or inter-sectoral programmes in order to achieve the national socio-demographic goals for 2010. These are presented below:

(i) Decentralised Planning and Programme Implementation

2 The 73rd and 74th Constitutional Amendments Act, 1992, made health, family welfare, and education a responsibility of village panchayats. The panchayati raj institutions are an important means of furthering decentralised planning and programme implementation in the context of the NPP 2000. However, in order to realize their potential, they need strengthening by further delegation of administrative and financial powers, including powers of resource mobilization.

Further, since 33 percent of elected panchayat seats are reserved for women, representative committees of the panchayats (headed by an elected woman panchayat member) should be formed to promote a gender sensitive, multi-sectoral agenda for population stabilisation, that will "think, plan and act locally, and support nationally". These committees may identify areaspecific unmet needs for reproductive health services, and prepare need-based, demanddriven, socio-demographic plans at the village level, aimed at identifying and providing responsive, people-centred and integrated, basic reproductive and child health care. Panchayats demonstrating exemplary performance in the compulsory registration of births, deaths, marriages, and pregnancies, universalizing the small family norm, increasing safe deliveries, bringing about reductions in infant and maternal mortality, and promoting compulsory education up to age 14, will be nationally recognized and honored.

(ii) Convergence of Service Delivery at Village Levels

3 Efforts at population stabilisation will be effective only if we direct an integrated package of essential services at village and household levels. Below district levels, current health infrastructure includes 2,500 community health centres, 25,000 primary health centres (each covering a population of 30,000), and 1.36 lakh subcentres (each covering a population of 5,000 in the plains and 3,000 in hilly regions)⁴. Inadequacies in the existing health infrastructure have led to an unmet need of 28 percent for contraception services, and obvious gaps in coverage and outreach. Health care centres are over-burdened and struggle to provide services with limited personnel and equipment. Absence of supportive supervision, lack of training in inter-personal communication, and lack of motivation to work in rural areas, together impede citizens' access to reproductive and child health services, and contribute to poor quality of services and an apparent insensitivity to client's needs. The last 50 years have demonstrated the unsuitability of these yardsticks for provision of health care infrastructure, particularly for remote, inaccessible, or sparsely populated regions in the country like hilly and forested areas, desert regions and tribal areas. We need to promote a more flexible approach, by extending basic reproductive and child health care through mobile clinics and counseling services. Further, recognizing that government alone cannot make up for the inadequacies in health care infrastructure and services, in order to resolve unmet needs and extend coverage, the involvement of the voluntary sector and the non-government sector in partnership with the government is essential.

4	<p>Since the management, funding, and implementation of health and education programmes has been decentralised to panchayats, in order to reach household levels, a one-stop, integrated and coordinated service delivery should be provided at village levels, for basic reproductive and child health services. A vast increase in the number of trained birth attendants, at least two per village, is necessary to universalise coverage and outreach of ante-natal, natal and post-natal health care. An equipped maternity hut in each village should be set up to serve as a delivery room, with functioning midwifery kits, basic medication for essential obstetric aid, and indigenous medicines and supplies for maternal and new born care. A key feature of the integrated service delivery will be the registration at village levels, of births, deaths, marriage, and pregnancies. Each village should maintain a list of community midwives and trained birth attendants, village health guides, panchayat sewa sahayaks, primary school teachers and aanganwadi workers who may be entrusted with various responsibilities in the implementation of integrated service delivery.</p> <p>⁴ Source: MOHFW Statistics, 1998.</p>
5	<p>The panchayats should seek the help of community opinion makers to communicate the benefits of smaller, healthier families, the significance of educating girls, and promoting female participation in paid employment. They should also involve civil society in monitoring the availability, accessibility and affordability of services and supplies.</p> <p>Operational strategies are described in the Action Plan at Appendix I.</p> <p><i>(iii) Empowering Women for Improved Health and Nutrition</i></p>
6	<p>The complex socio-cultural determinants of women's health and nutrition have cumulative effects over a lifetime. Discriminatory childcare leads to malnutrition and impaired physical development of the girl child. Undernutrition and micronutrient deficiency in early adolescence goes beyond mere food entitlements to those nutrition related capabilities that become crucial to a woman's well-being, and through her, to the well-being of children. The positive effects of good health and nutrition on the labour productivity of the poor is well documented. To the extent that women are over-represented among the poor, interventions for improving women's health and nutrition are critical for poverty reduction.</p>
7	<p>Impaired health and nutrition is compounded by early childbearing, and consequent risk of serious pregnancy related complications. Women's risk of premature death and disability is highest during their reproductive years. Malnutrition, frequent pregnancies, unsafe abortions, RTI and STI, all combine to keep the maternal mortality ratio in India among the highest globally.</p>
8	<p>Maternal mortality is not merely a health disadvantage, it is a matter of social injustice. Low social and economic status of girls and women limits their access to education, good nutrition, as well as money to pay for health care and family planning services. The extent of maternal mortality is an indicator of disparity and inequity in access to appropriate health care and nutrition services throughout a lifetime, and particularly during pregnancy and child-birth, and is a crucial factor contributing to high maternal mortality.</p>
9	<p>Programmes for Safe Motherhood, Universal Immunisation, Child Survival and Oral Rehydration have been combined into an Integrated Reproductive and Child</p>

	Health Programme, which also includes promoting management of STIs and RTIs. Women's health and nutrition problems can be largely prevented or mitigated through low cost interventions designed for low income settings.
10	<p>The voluntary non-government sector and the private corporate sector should actively collaborate with the community and government through specific commitments in the areas of basic reproductive and child health care, basic education, and in securing higher levels of participation in the paid work force for women.</p> <p>Operational strategies are described in the Action Plan at Appendix I.</p> <p><i>(iv) Child Health and Survival</i></p>
11	<p>Infant mortality is a sensitive indicator of human development. High mortality and morbidity among infants and children below 5 years occurs on account of inadequate care, asphyxia during birth, premature birth, low birth weight, acute respiratory infections, diarrhoea, vaccine preventable diseases, malnutrition and deficiencies of nutrients, including Vitamin A. Infant mortality rates have not significantly declined in recent years.</p>
12	<p>Our priority is to intensify neo-natal care. A National Technical Committee should be set up, consisting principally of consultants in obstetrics, pediatrics (neonatologists), family health, medical research and statistics from among academia, public health professionals, clinical practitioners and government. Its terms of reference should include prescribing perinatal audit norms, developing quality improvement activities with monitoring schedules and suggestions for facilitating provision of continuing medical and nursing education to all perinatal health care providers. Implementation at the grass-roots must benefit from current developments in the fields of perinatology and neonatology. The baby friendly hospital initiative (BFHI) should be extended to all hospitals and clinics, up to subcentre levels. Additionally, besides promoting breast-feeding and complementary feeds, the BFHI should include updating of skills of trained birth attendants to improve new born care practices to reduce the risks of hypothermia and infection. Essential equipment for the new born must be provided at subcentre levels.</p>
13	<p>Child survival interventions i.e. universal immunisation, control of childhood diarrhoeas with oral rehydration therapies, management of acute respiratory infections, and massive doses of Vitamin A and food supplements have all helped to reduce infant and child mortality and morbidity. With intensified efforts, the eradication of polio is within reach. However, the decline in standards, outreach and quality of routine immunisation is a matter of concern. Significant improvements need to be made in the quality and coverage of the routine immunisation programme.</p> <p>Operational strategies are described in the Action Plan at Appendix I.</p> <p><i>(v) Meeting the Unmet Needs for Family Welfare Services</i></p>
14	<p>In both rural and urban areas there continue to be unmet needs for contraceptives, supplies and equipment for integrated service delivery, mobility of health providers and patients, and comprehensive information. It is important to strengthen, energise and make accountable the cutting edge of health infrastructure at the village, subcentre and primary health centre levels, to</p>

improve facilities for referral transportation, to encourage and strengthen local initiatives for ambulance services at village and block levels, to increase innovative social marketing schemes for affordable products and services and to improve advocacy in locally relevant and acceptable dialects.

Operational strategies are described in the Action Plan in [Appendix I](#).

(vi) Under-Served Population Groups

(a) Urban Slums

- 15 Nearly 100 million people live in urban slums, with little or no access to potable water, sanitation facilities, and health care services. This contributes to high infant and child mortality, which in turn perpetuate high TFR and maternal mortality. Basic and primary health care, including reproductive and child health care, needs to be provided. Coordination with municipal bodies for water, sanitation and waste disposal must be pursued, and targeted information, education and communication campaigns must spread awareness about the secondary and tertiary facilities available.

Operational strategies are described in the Action Plan in [Appendix I](#).

(b) Tribal Communities, Hill Area Populations and Displaced and Migrant Populations

- 16 In general, populations in remote and low density areas do not have adequate access to affordable health care services. Tribal populations often have high levels of morbidity arising from poor nutrition, particularly in situations where they are involuntarily displaced or resettled. Frequently, they have low levels of literacy, coupled with high infant, child, and maternal mortality. They remain under-served in the coverage of reproductive and child health services. These communities need special attention in terms of basic health, and reproductive and child health services. The special needs of tribal groups which need to be addressed include the provision of mobile clinics that will be responsive to seasonal variations in the availability of work and income. Information and counseling on infertility, and regular supply of standardised medication will be included.

Operational strategies are described in the Action Plan at [Appendix I](#).

(c) Adolescents

- 17 Adolescents represent about a fifth of India's population. The needs of adolescents, including protection from unwanted pregnancies and sexually transmitted diseases (STD), have not been specifically addressed in the past. Programmes should encourage delayed marriage and child-bearing, and education of adolescents about the risks of unprotected sex. Reproductive health services for adolescent girls and boys is especially significant in rural India, where adolescent marriage and pregnancy are widely prevalent. Their special requirements comprise information, counseling, population education, and making contraceptive services accessible and affordable, providing food supplements and nutritional services through the ICDS, and enforcing the Child Marriage Restraint Act, 1976.

Operational strategies are described in the Action Plan in [Appendix I](#).

(d) Increased Participation of Men in Planned Parenthood

- 18 In the past, population programmes have tended to exclude menfolk. Gender inequalities in patriarchal societies ensure that men play a critical role in determining the education and employment of family members, age at marriage, besides access to and utilisation of health, nutrition, and family welfare services for women and children. The active involvement of men is called for in planning families, supporting contraceptive use, helping pregnant women stay healthy, arranging skilled care during delivery, avoiding delays in seeking care, helping after the baby is born and, finally, in being a responsible father. In short, the active cooperation and participation of men is vital for ensuring programme acceptance. Further, currently, over 97 percent of sterilisations are tubectomies and this manifestation of gender imbalance needs to be corrected. The special needs of men include re-popularising vasectomies, in particular noscalpel vasectomy as a safe and simple procedure, and focusing on men in the information and education campaigns to promote the small family norm.

Operational strategies are described in the Action Plan in [Appendix I](#).

(vii) Diverse Health Care Providers

- 19 Given the large unmet need for reproductive and child health services, and inadequacies in health care infrastructure it is imperative to increase the numbers and diversify the categories of health care providers. Ways of doing this include accrediting private medical practitioners and assigning them to defined beneficiary groups to provide these services; revival of the system of licensed medical practitioner who, after appropriate certification from the Indian Medical Association (IMA), could provide specified clinical services.

Operational strategies are described in the Action Plan at [Appendix I](#).

(viii) Collaboration With and Commitments from Non-Government Organisations and the Private Sector

- 20 A national effort to reach out to households cannot be sustained by government alone. We need to put in place a partnership of non-government voluntary organizations, the private corporate sector, government and the community. Triggered by rising incomes and institutional finance, private health care has grown significantly, with an impressive pool of expertise and management skills, and currently accounts for nearly 75 percent of health care expenditures. However, despite their obvious potential, mobilising the private (profit and non-profit) sector to serve public health goals raises governance issues of contracting, accreditation, regulation, referral, besides the appropriate division of labour between the public and private health providers, all of which need to be addressed carefully. Where government interventions or capacities are insufficient, and the participation of the private sector unviable, focused service delivery by NGOs may effectively complement government efforts.

Operational strategies are described in the Action Plan in [Appendix I](#).

(ix) Mainstreaming Indian Systems of Medicine and Homeopathy

21	<p>India's community supported ancient but living traditions of indigenous systems of medicine has sustained the population for centuries, with effective cures and remedies for numerous conditions, including those relating to women and children, with minimal side effects. Utilisation of ISMH in basic reproductive and child health care will expand the pool of effective health care providers, optimise utilisation of locally based remedies and cures, and promote lowcost health care. Guidelines need to be evolved to regulate and ensure standardisation, efficacy and safety of ISMH drugs for wider entry into national markets.</p>
22	<p>Particular challenges include providing appropriate training, and raising awareness and skill development in reproductive and child health care to the institutionally qualified ISMH medical practitioners. The feasibility of utilising their services to fill in gaps in manpower at village levels, and at subcentres and primary health centres may be explored. ISMH institutions, hospitals and dispensaries may be utilised for reproductive and child health care programmes. At village levels, the services of the ISMH "barefoot doctors", after appropriate training, may be utilised for advocacy and counseling, for distributing supplies and equipment, and as depot holders. ISMH practices may be applied at village maternity huts, and at household levels, for ante-natal, natal and post natal care, and for nurture of the new born.</p> <p>Operational strategies are described in the Action Plan in Appendix I.</p> <p><i>(x) Contraceptive Technology and Research on Reproductive and Child Health</i></p>
23	<p>Government must constantly advance, encourage, and support medical, social science, demographic and behavioural science research on maternal, child and reproductive health care issues. This will improve medical techniques relevant to the country's needs, and strengthen programme and project design and implementation. Consultation and frequent dialogue by Government with the existing network of academic and research institutions in allopathy and ISMH, and with other relevant public and private research institutions engaged in social science, demography and behavioural research must continue. The International Institute of Population Sciences, and the population research centres which have been set up to pursue applied research in population related matters, need to be revitalised and strengthened.</p>
24	<p>Applied research relies upon constant monitoring of performance at the programme and project levels. The National Health and Family Welfare Survey provides data on key health and family welfare indicators every five years. Data from the first National Family Health Survey (NFHS- 1), 1992-93, has been updated by NFHS-2, 1998-99, to be published shortly. Annual data is generated by the Sample Registration Survey, which, inter alia, maps at state levels the birth, death and infant mortality rates. Absence of regular feedback has been a weakness in the family welfare programme. For this reason, the Department of Family Welfare is strengthening its management information systems (MIS) and has commenced during 1998, a system of ascertaining impacts and outcomes through district surveys and facility surveys. The district surveys cover 50% districts every year, so that every 2 years there is an update on every district in the country. The facility surveys ascertain the availability of infrastructure and services up to primary health centre level, covering one district per month. The feedback from both these surveys enable remedial action at district and sub-</p>

	<p>district levels.</p> <p>Operational strategies are described in the Action Plan in Appendix I.</p> <p><i>(xi) Providing for the Older Population</i></p>
25	<p>Improved life expectancy is leading to an increase in the absolute number and proportion of persons aged 60 years and above, and is anticipated to nearly double during 1996-2016, from 62.3 million to 112.9 million⁵. When viewed in the context of significant weakening of traditional support systems, the elderly are increasingly vulnerable, needing protection and care. Promoting old age health care and support will, over time, also serve to reduce the incentive to have large families.</p>
26	<p>The Ministry of Social Justice and Empowerment has adopted in January 1999 a National Policy on Older Persons. It has become important to build in geriatric health concerns in the population policy. Ways of doing this include sensitising, training and equipping rural and urban health centres and hospitals for providing geriatric health care; encouraging NGOs to design and implement formal and informal schemes that make the elderly economically self-reliant; providing for and routinising screening for cancer, osteoporosis, and cardiovascular conditions in primary health centres, community health centres, and urban health care centres at primary, secondary and tertiary levels; and exploring tax incentives to encourage grown-up children to look after their aged parents.</p> <p>Operational strategies are described in the Action Plan in Appendix I.</p> <p><i>(xii) Information, Education, and Communication</i></p>
27	<p>Information, education and communication (IEC) of family welfare messages must be clear, focused and disseminated everywhere, including the remote corners of the country, and in local dialects. This will ensure that the messages are effectively conveyed. These need to be strengthened and their outreach widened, with locally relevant, and locally comprehensible media and messages. On the model of the total literacy campaigns which have successfully mobilised local populations, there is need to undertake a massive national campaign on population related issues, via artists, popular film stars, doctors, vaidyas, hakims, nurses, local midwives, women's organizations, and youth organizations.</p> <p>Operational strategies are described in the Action Plan in Appendix I.</p>

LEGISLATION, PUBLIC SUPPORT & NEW STRUCTURES

LEGISLATION

As a motivational measure, in order to enable state governments to fearlessly and effectively pursue the agenda for population stabilisation contained in the National Population Policy, 2000, one legislation is considered necessary. It is recommended that the 42nd Constitutional Amendment that freezes till 2001, the number of seats to the Lok Sabha and the Rajya Sabha based on the 1971 Census be extended up to 2026.

PUBLIC SUPPORT

Demonstration of strong support to the small family norm, as well as personal example, by political, community, business, professional and religious leaders, media and film stars, sports personalities, and opinion makers, will enhance its acceptance throughout society. The government will actively enlist their support in concrete ways.

NEW STRUCTURES

The NPP 2000 is to be largely implemented and managed at panchayat and nagar palika levels, in coordination with the concerned state/Union Territory administrations. Accordingly, the specific situation in each state/UT must be kept in mind. This will require comprehensive and multisectoral coordination of planning and implementation between health and family welfare on the one hand, along with schemes for education, nutrition, women and child development, safe drinking water, sanitation, rural roads, communications, transportation, housing, forestry development, environmental protection, and urban development. Accordingly, the following structures are recommended:

(i) National Commission on Population

A National Commission on Population, presided over by the Prime Minister, will have the Chief Ministers of all states and UTs, and the Central Minister in charge of the Department of Family Welfare and other concerned Central Ministries and Departments, for example Department of Woman and Child Development, Department of Education, Department of Social Justice and Empowerment in the Ministry of HRD, Ministry of Rural Development, Ministry of Environment and Forest, and others as necessary, and reputed demographers, public health professionals, and NGOs as members. This Commission will oversee and review implementation of policy. The Commission Secretariat will be provided by the Department of Family Welfare.

(ii) State / UT Commissions on Population

Each state and UT may consider having a State / UT Commission on Population, presided over by the Chief Minister, on the analogy of the National Commission, to likewise oversee and review implementation of the NPP 2000 in the state / UT.

(iii) Coordination Cell in the Planning Commission

The Planning Commission will have a Coordination Cell for inter-sectoral coordination between Ministries for enhancing performance, particularly in States/UTs needing special attention on account of adverse demographic and human development indicators.

(iv) Technology Mission in the Department of Family Welfare

To enhance performance, particularly in states with currently below average socio-demographic indices that need focused attention, a Technology Mission in the Department of Family Welfare will be established to provide technology support in respect of design and monitoring of projects and programmes for reproductive and child health, as well as for IEC campaigns.

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FUNDING, PROMOTIONAL AND MOTIVATIONAL MEASURES FOR ADOPTION OF THE SMALL FAMILY NORM

FUNDING

The programmes, projects and schemes premised on the goals and objectives of the NPP 2000, and indeed all efforts at population stabilisation, will be adequately funded in view of their critical importance to national development. Preventive and promotive services such as ante-natal and post-natal care for women, immunisation for children, and contraception will continue to be subsidised for all those who need the services. Priority in allocation of funds will be given to improving health care infrastructure at the community and primary health centres, subcentre and village levels. Critical gaps in manpower will be remedied through redeployment, particularly in under-served and inaccessible areas, and referral linkages will be improved. In order to implement immediately the Action Plan, it would be necessary to double the annual budget of the Department of Family Welfare to enable government to address the shortfall in unmet needs for health care infrastructure, services and supplies (in [Appendix IV](#)).

Even though the annual budget for population stabilisation activities assigned to the Department of Family Welfare has increased over the years, at least 50 percent of the budgetary outlay is deployed towards non-plan activities (recurring expenditures for maintenance of health care infrastructure in the states and UTs, and towards salaries). To illustrate, of the annual budget of Rs. 2920 crores for 1999-2000, nearly Rs 1500 crores is allocated towards non-plan activities. Only the remaining 50 percent becomes available for genuine plan activities, including procurement of supplies and equipment. For these reasons, since 1980 the Department of Family Welfare has been unable to revise norms of operational costs of health infrastructure, which in turn has impacted directly the quality of care and outreach of services provided.

PROMOTIONAL AND MOTIVATIONAL MEASURES FOR ADOPTION OF THE SMALL FAMILY NORM

The following promotional and motivational measures will be undertaken:

(i) Panchayats and Zila Parishads will be rewarded and honoured for exemplary performance in universalising the small family norm, achieving reductions in infant mortality and birth rates, and promoting literacy with completion of primary schooling.

(ii) The Balika Samridhi Yojana run by the Department of Women and Child Development, to promote survival and care of the girl child, will continue. A cash incentive of Rs. 500 is awarded at the birth of the girl child of birth order 1 or 2.

(iii) Maternity Benefit Scheme run by the Department of Rural Development will continue. A cash incentive of Rs. 500 is awarded to mothers who have their first child after 19 years of age, for birth of the first or second child only. Disbursement of the cash award will in future be linked to compliance with ante-natal check up, institutional delivery by trained birth attendant, registration of birth and BCG immunisation.

(iv) A Family Welfare-linked Health Insurance Plan will be established. Couples below the poverty line, who undergo sterilisation with not more than two living children, would become eligible (along with children) for health insurance (for hospitalisation) not exceeding Rs. 5000, and a personal accident insurance cover for the spouse undergoing sterilisation.

(v) Couples below the poverty line, who marry after the legal age of marriage, register the marriage, have their first child after the mother reaches the age of 21, accept the small family norm, and adopt a terminal method after the birth of the second child, will be rewarded.

(vi) A revolving fund will be set up for income-generating activities by village-level self help groups, who provide community-level health care services.

(vii) Crèches and child care centres will be opened in rural areas and urban slums. This will facilitate and promote participation of women in paid employment.

(viii) A wider, affordable choice of contraceptives will be made accessible at diverse delivery points, with counseling services to enable acceptors to exercise voluntary and informed consent.

(ix) Facilities for safe abortion will be strengthened and expanded.

(x) Products and services will be made affordable through innovative social marketing schemes.

(xi) Local entrepreneurs at village levels will be provided soft loans and encouraged to run ambulance services to supplement the existing arrangements for referral transportation.

(xii) Increased vocational training schemes for girls, leading to self-employment will be encouraged.

(xiii) Strict enforcement of Child Marriage Restraint Act, 1976.

(xiv) Strict enforcement of the Pre-Natal Diagnostic Techniques Act, 1994.

(xv) Soft loans to ensure mobility of the ANMs will be increased.

(xvi) The 42nd Constitutional Amendment has frozen the number of representatives in the Lok Sabha (on the basis of population) at 1971 Census levels. The freeze is currently valid until 2001, and has served as an incentive for State Governments to fearlessly pursue the agenda for population stabilisation. This freeze needs to be extended until 2026.

CONCLUSION

In the new millenium, nations are judged by the well-being of their peoples; by levels of health, nutrition and education; by the civil and political liberties enjoyed by their citizens; by the protection guaranteed to children and by provisions made for the vulnerable and the disadvantaged.

The vast numbers of the people of India can be its greatest asset if they are provided with the means to lead healthy and economically productive lives. Population stabilisation is a multisectoral endeavour requiring constant and effective dialogue among a diversity of stakeholders, and coordination at all levels of the government and society. Spread of literacy and education, increasing availability of affordable reproductive and child health services, convergence of service delivery at village levels, participation of women in the paid work force, together with a steady, equitable improvement in family incomes, will facilitate early achievement of the socio-demographic goals. Success will be achieved if the Action Plan contained in the NPP 2000 is pursued as a national movement.